Coping with death

How doctors cope with death

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Perspective on the paper by Baverstock and Finlay (see page 774)

Modern medicine focuses largely on treatment and cure, but care of the dying and bereaved remains an important duty of a doctor. After the death of a child, healthcare professionals are required to help support bereaved families. However, medical staff may feel ill prepared to do so.

In this issue, Baverstock *et al*[1] report some of the emotions experienced by paediatric specialist registrars dealing with the recent death of a patient and the coping mechanisms the registrars used. There is little previously published on the topic but the importance the survey respondents attached to this issue is reflected in the high response rate.

Registrars report various emotional reactions to the death of a child. A sudden death produces a feeling of shock. Registrars also report self doubt, which may be a reflection of inexperience. Skill and confidence in communication with a bereaved family can be taught and are enhanced with practice.

Doctors may struggle to support a family when they are not prepared for their own emotional response that the death of a patient can elicit. Individuals may personalise a tragedy happening in another family. This internalisation may increase the perceived vulnerability and emotions experienced. This may be especially difficult for doctors who are parents of young children.

When a child dies, doctors inevitably question the quality of care delivered. Uncertainty in the mind of the physician regarding the treatment delivered can increase the emotional response felt. Mistakes or substandard care may make adverse emotions especially difficult to reconcile, irrespective of seniority.

Although death is a tragedy, sometimes there is professional satisfaction when the palliative care outcome is a peaceful death, free of pain.

If doctors are familiar with the emotions that they normally experience after the death of a patient, individuals may be able to alter their behaviour in order to provide professional support to the bereaved. However, doctors should not lose empathy.

Physicians use several strategies for dealing with the emotional response to a child's death. Some experienced physicians deal with difficult situations by externalising the problem or by becoming a little numb. Another strategy, often the subject of medical satire, is the morbid sense of humour present in many departments dealing with the most difficult tragedies. To newcomers, this humour is initially found distasteful but is quickly learned; no one finds death funny but it is often used as a defence mechanism.

Registrars feel they need support. Experts disagree on the best form of support that should be offered to healthcare workers who have to deal with paediatric deaths.[2] There is popular support for the process of debriefing. ''Psychological debriefing'' is a technique used to try to mitigate long term consequences of exposure to ''critical incident stress'' such as the death of a child. The value of psychological debriefing has been questioned in a recent Cochrane review and is currently not recommended for healthcare professionals, as it may increase the risk of post-traumatic stress disorder.[3]

Training in breaking bad news and end of life management can give the doctor a framework to use when dealing with bereaved families. Awareness of the medical and legal procedures required after death can act as a starting point for discussion. Knowledge of the grief process allows some understanding of families' behaviour after bereavement. This training and knowledge is important to allow the doctor to feel more comfortable in talking to families, but does not provide specific emotional support for the doctor.

It seems in the nature of things that specialist registrars should look to their consultants for support. The fragmentation of the medical firm and shift patterns makes this more difficult. Senior nurses can help. They are often less embarrassed to show their own emotion and do provide support to medical staff.

Baverstock *et al* appeal for ''accessible constructive support.'' Formal training on dealing with paediatric death is often not easily accessible. Training offered often concentrates on the procedures that follow a death rather than how to cope emotionally with death.

A charitable organisation, the Child Bereavement Trust, provides bereavement training with sessions specifically dealing with the emotional issues professionals may face when dealing with paediatric deaths.[4] This training is tailored to provide pre-emptive discussion of the emotional responses that the death of a child is likely to evoke in medical staff, and is to be commended.

Support is most effective if it is provided in the workplace.[5] This support from peers and seniors should be voluntary and non-intrusive and should not seek to psychologically counsel the individual. It should provide a listening ear with simple support and encouragement. The role of the senior or ''respected veteran'' is important in facilitating and giving credibility to the process. Consultants may fill this role but they will also need training and support.

Finally, it is important to recognise maladaptive strategies, such as alcohol and substance misuse, early. Most Trusts offer confidential counselling free to employees. Employers also need to be vigilant in detecting post-traumatic stress disorder.

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